CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 20, 2000

S. 662
Breast and Cervical Cancer Prevention and Treatment Act of 2000

As ordered reported by the Senate Committee on Finance on June 14, 2000

SUMMARY

S. 662 would allow states to receive federal Medicaid funds for providing medical care to low-income women who have been screened under a Centers for Disease Control and Prevention (CDC) screening program and found to have breast or cervical cancer. CBO estimates that S. 662 would increase direct spending by $250 million over the 2000-2005 period. Since this bill would affect direct spending, pay-as-you-go procedures would apply.

S. 662 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). A new coverage option in the bill would allow states to increase spending in their Medicaid programs for the treatment of breast and cervical cancer. CBO estimates that the state portion of Medicaid expenditures for this optional coverage would total $107 million over the 2000-2005 period.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 662 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	15	35	50	65	85
Estimated Outlays	0	15	35	50	65	85

BASIS OF ESTIMATE

S. 662 would give states the option of providing Medicaid coverage to women who have been screened under the CDC's National Breast and Cervical Cancer Early Detection Program and found to have breast or cervical cancer. States would receive an enhanced federal Medicaid match rate for services provided to women who become eligible for Medicaid under the bill. (This enhanced federal match rate, which is already used for services provided under the State Children's Health Insurance Program, averages about 70 percent, compared to 57 percent for the regular match rate.) Federal Medicaid funds would be available beginning in fiscal year 2001.

Under current law, women with breast or cervical cancer are eligible for Medicaid only if they fall into an existing eligibility category. The principal eligibility categories for low-income women are pregnancy, and welfare-related or disability-related coverage (which is largely based on receipt of either Temporary Assistance for Needy Families or Supplemental Security Income). If a woman is found to have breast or cervical cancer, does not have health insurance, and does not qualify for Medicaid, she either pays for the treatment with her own funds, receives treatment through a state, local, or privately funded program, receives charity care, or goes without treatment.

The Congress created the National Breast and Cervical Cancer Early Detection Program in 1990 and appropriated $166 million for the program for fiscal year 2000. The funds support screening activities in all 50 states, in the District of Columbia and U.S. territories, and for several American Indian/Alaska Native organizations. States set their own income eligibility levels, at or below 250 percent of the federal poverty line. Most states have set eligibility criteria at about 200 percent of poverty. The CDC estimates that the program currently screens about 15 percent of the eligible population. Program funds are not available for treating breast and cervical cancer.

The bill's effect on federal Medicaid spending depends on the number of women who would receive Medicaid-funded treatment as a result of the bill, the cost of the treatment, and the number of states that would choose the option. The following discussion focuses on the estimate for breast cancer treatment, which accounts for over 90 percent of the estimated costs of the bill. A brief discussion of the cost of cervical cancer treatment can be found at the end of the section.

Number of beneficiaries. The states provided 224,000 mammograms with funds available under the CDC screening program in 1998. Some states currently supplement the CDC screening funds with their own funds for screening, diagnosis, and treatment. Under the bill, CBO expects that the number of mammograms under the CDC program would rise to 540,000 by 2005, as states that fund diagnosis and treatment services redirect their funds to

supplement the screening funds in the CDC program. Because participation in that program would provide access to federal Medicaid funds for diagnosis and treatment of breast cancer, states would have an incentive to redirect their own funds into the CDC screening program.

Of women screened for breast cancer by the CDC program since its inception, about 0.5 percent, or 5 per 1,000, have been found to have breast cancer. Another 7 percent have had abnormal screens that required additional diagnosis and perhaps minor treatment. CBO assumes that the same incidence of cancer and other abnormal results would continue under the bill, resulting in the identification of about 2,700 new cancers and 36,000 abnormal mammograms each year by 2005.

In addition to these new cases, CDC reports that it has already diagnosed over 5,800 breast cancers. CBO anticipates that about 2,400 of these women would receive coverage under the bill if states adopt the option.

Cost of treatment. Based on data from a large health maintenance organization, CBO has estimated the average cost of breast cancer treatment by age and year since diagnosis. In the first year after diagnosis, CBO estimates that cancer treatment would cost about $20,000. In subsequent years, CBO estimates about $6,000 a year in ongoing care costs, until the last year of a patient's life, when costs total about $33,000. CBO used information from the National Cancer Institute's Surveillance, Epidemiology, and End Results Program to estimate age-specific mortality rates from the time of diagnosis.

For women who have an abnormal mammogram, but who are not ultimately diagnosed with cancer, CBO estimates average treatment costs of about $2,000 in the year after the mammogram for follow-up diagnostic and treatment services.

The costs discussed above are for cancer treatment only and are expressed in fiscal year 2001 dollars. Because the bill would extend full Medicaid coverage during the time the woman needs cancer treatment, CBO added about $1,000 a year to the costs of cancer treatment (one-third of the average per capita Medicaid costs for adults) to determine total Medicaid costs for women newly eligible because of the bill. CBO expects that the average annual cost of treatment would rise at the same rate as the Consumer Price Index for medical care (CPI-M).

State participation. In 2001, CBO anticipates that states with 25 percent of potential Medicaid costs would choose to cover breast cancer patients screened through the CDC program in their Medicaid programs. By 2005, CBO projects that proportion would rise to 50 percent.

Cervical cancer. The costs of cervical cancer treatment under the bill stem principally from treatment of pre-cancerous conditions since screening often results in an abnormal finding at an early stage of the disease. CBO anticipates that about 120 new cases of cervical cancer would be diagnosed each year under the screening program, with average annual treatment costs similar to the treatment costs for breast cancer. CBO expects about 10,000 abnormal pap smears each year, with treatment costs averaging $1,000 to $2,000. In total, CBO estimates that treatment of cervical cancer under the bill would cost $15 million over the 2000-2005 period.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in the following table. (S. 662 would not affect receipts.) For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	15	35	50	65	85	105	120	145	165	190
Changes in receipts	Not applicable										

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

S. 662 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act. The bill would allow states to increase spending in their Medicaid programs for the treatment of breast and cervical cancer. CBO estimates that the state portion of Medicaid expenditures for this optional coverage would total $107 million over the 2000-2005 period.

State spending for the treatment of breast and cervical cancer among certain women who would otherwise be ineligible for Medicaid would qualify for a 70 percent federal match on average. Some states may already be covering this type of treatment in state-funded public health programs. In those cases, the federal matching funds would allow states to increase their overall level of spending for existing programs or to redirect a portion of their current spending to screening or other state programs.

PREVIOUS CBO ESTIMATE

On November 10, 1999, CBO estimated that section 2 of H.R. 1070, as ordered reported by the House Committee on Commerce on October 28, 1999, would increase federal Medicaid spending by $205 million over the 2000-2004 period. The provisions of that section are almost identical to those in S. 662, except for the federal match rate that would apply to Medicaid services provided under the new state option. Under H.R. 1070, the federal match rate would be 75 percent or the state's regular rate, whichever is higher. Since the federal match rate under S. 662 would generally be lower (70 percent, on average), CBO assumed that state participation in the new Medicaid option would also be lower. CBO's estimate for S. 662 also incorporates more recent data on the CDC screening program, new projections for the CPI-M, and budgetary effects in 2005.

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